

**Madison County Mental Health Board**

**Monthly Service Billing Voucher**

**Part 1.**

**Provider Name:** \_\_\_\_\_

**Service Month/Year:** \_\_\_\_\_

<b>Program</b>	<b>Units Contracted</b>	<b>Units Provided</b>	<b>Unit Rate</b>	<b>Amount Billed</b>
<b>Total</b>				

**Totals:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
=====

**Part 2.**

**Mental Health Board Review:**

**Approved Payment Amount: \$** \_\_\_\_\_

**By:** \_\_\_\_\_ **Date:** \_\_\_\_\_